

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6283 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06258

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Queen Ann				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural—Cambridge		c. LENGTH OF STAY IN 1b 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Queenstown		d. STREET ADDRESS none				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eastern Shore State Hospital				d. STREET ADDRESS none		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) James Frances Boyles		First	Middle	Last	4. DATE OF DEATH June 23 1957	Month	Day	Year		
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1866	9. AGE (in years last birthday) 90 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Gen. Farming		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown <input checked="" type="checkbox"/>		17. INFORMANT Records Eastern Shore State Hospital		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 420.1 (b) Generalized Arteriosclerosis. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 450.0										
INTERVAL BETWEEN ONSET AND DEATH 2-10 Min.										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. NO		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) -----								
20c. TIME OF INJURY Month, Day, Year Hour q. m. ----- p. m. ----- 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) -----		(County) -----	(State) -----	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/>										
ACTUAL SIGNATURE Eldridge H. Wolff		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>							DATE SIGNED 23 June 1957	
EXAMINER'S NAME (Type) Eldridge H. Wolff, M.D.										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 26, 1957		22c. NAME OF CEMETERY OR CREMATORIAL Chesapeake Cemetery		22d. LOCATION (City, town, or county) Centreville, Maryland		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE James H. Batten, Jr., of Batten Bros. Centreville, Md.		ADDRESS		24a. REC'D BY REGISTRAR John Macay		24b. REGISTRAR'S SIGNATURE John Macay		DATE 6/27/57		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

DEPARTMENT OF HEALTH-DEATH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 8

JUL 1 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6284

06259

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Wicomico		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural—Cambridge		c. LENGTH OF STAY IN 1b 1½ Months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fruitland (Green & Parsonage Streets)		d. STREET ADDRESS Rural—Cambridge, Wicomico, Md. Fruitland.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eastern Shore State Hospital								
3. NAME OF DECEASED (Type or print) Nettie May Brumbley		First	Middle	Last	4. DATE OF DEATH March 17. 1888	Month June	Day 23	Year 1957
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 1888 ?		8. AGE (In years at birthday) 68? yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Salisbury, Md (Rural)		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Samuel Glasgow				14. MOTHER'S MAIDEN NAME Ellen Layfield				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Records, Eastern Shore State Hospital and				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X		DUE TO Cerebral accident		Mrs. Agnes Causey (Sister) Fruitland, Md.				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Arteriosclerosis, generalized		DUE TO two days						
DUE TO two yrs plus								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Rt. Hip Fracture, prior to admission to BSS Hosp. on 5-12-57						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. 9040		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Dec. slipped and fell, about a week prior to admission.						
20c. TIME OF INJURY ? Hour a. m. 5/5/57 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Fruitland, Wicomico, Md.		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/>								
ACTUAL SIGNATURE Eldridge H. Wolff								
EXAMINER'S NAME (Type) Eldridge H. Wolff, M. D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/26/57		22c. NAME OF CEMETERY OR CREMATORIUM St. Johns		22d. LOCATION (City, town, or county) Fruitland, Wicomico, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Holloway & Co., Salisbury, Md.		ADDRESS St. Johns		24a. REC'D BY REGISTRAR CERN.		24b. REGISTRAR'S SIGNATURE John Nease Jr.		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. 4

JUN 27 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1 Item 20b Film 210 6-17-57 ans MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06260

6269

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Died on way to hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vienna	
3. NAME OF -DECEASED (Type or print) Cheryl		First Germaine	Middle Cephas
4. DATE OF DEATH June 9 1957		5. SEX Female	6. COLOR OR RACE Negro
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Nov. 21, 1955	
9. AGE (in years last birthday) 1 yrs.		10. IF UNDER 1 YEAR Months 6 Days 9	11. IF UNDER 24 HRS. Hours 9 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Dorchester Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Cleamon W Cephas		14. MOTHER'S MAIDEN NAME Ida Marie Jackson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Ida M. Cephas, R.F.D. #1, Vienna, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial Injury DUE TO 812X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Multiple Fractures of Skull DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Run over by auto	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Run over by auto	
20c. TIME OF INJURY Hour 11 p.m. 6/9/57 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway
20f. (City or town) Bucktown		(County) (State) Dorchester Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Mace Jr.</i>		DATE SIGNED M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 6/11/57	
22a. BURIAL/CREMATION, 22b. DATE THEREOF REMOVAL (Specify) Burial 6/11/1957		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Bucktown Cemetery Cambridge, Md.	
22d. LOCATION (City, town, or county) Dorchester Co., Md.			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Richard M. St. Clair Jr.</i>		24a. REC'D BY REGISTRAR DATE 6/11/57	
24b. REGISTRAR'S SIGNATURE <i>John Mace Jr.</i>			

BUREAU V. 2

JUN 17 1957

RECEIVED

John M. Kelly

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6285

CERTIFICATE OF DEATH

Reg. Dist. No.

06261

1. PLACE OF DEATH a. COUNTY <i>Dorchester</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Seaford</i>		c. LENGTH OF STAY IN 1b <i>all life</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>Dor</i>	
						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x2 Seaford</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>—</i>				d. STREET ADDRESS <i>1 Main</i>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First <i>Susan</i>	Middle <i>Elizabeth</i>	Last <i>Collins</i>	4. DATE OF DEATH <i>4/22/1957</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>6/3/1872</i>	9. AGE (In years <i>85</i> on birthday) yrs.	10. UNDER 1 YEAR Months <i>—</i>	11. IF UNDER 24 HRS. Days <i>—</i>	12. DAY Year <i>1957</i>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Teacher (ret)</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Publischols</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
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13. FATHER'S NAME <i>Collard Collins</i>	14. MOTHER'S MAIDEN NAME <i>Eliza Rebecca Andrew</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>—</i>	17. INFORMANT <i>Mrs. G. Thompson, Seaford</i>	Address <i>—</i>

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Generalized Circumvirosis</i>	INTERVAL BETWEEN ONSET AND DEATH <i>6 mos.</i>
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>175x</i>	
(b) <i>Carcinoma of Ovary</i>	3 years
DUE TO (c) <i>—</i>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>450.0 Generalized Arterosclerosis</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>—</i>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>	20f. (City or town) (County) (State) <i>—</i>

21. I certify that I attended the deceased from <i>Seaford</i> , 19 <i>53</i> , to <i>Seaford</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>6/11/57</i> , 19 <i>57</i> , and that death occurred at <i>330 P.M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Seaford, Del. 1971-4</i>			
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ACTUAL SIGNATURE <i>D. B. Plummer</i>	M.D.	DATE SIGNED <i>6/26/57</i>
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PHYSICIAN'S NAME (Type) <i>Harold B. Plummer</i>	PLACE OF DEATH <i>Seaford, Del.</i>
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22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>6/25/57</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Washington</i>	22d. LOCATION (City, town, or county) <i>Seaford, Del.</i>
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23. FUNERAL DIRECTOR'S SIGNATURE <i>—</i>	ADDRESS <i>Seaford, Del.</i>	24a. REC'D BY REGISTRAR DATE <i>6/26/57</i>	24b. REGISTRAR'S SIGNATURE <i>John W. S.</i>
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CERTIFICATE OF DEATH

BUREAU V.

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RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06262

6286

CERTIFICATE OF DEATH

Reg. Dist. No.

116

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Wicomico		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN lb 4yr. 7mo. 11das.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela		d. STREET ADDRESS 228 22		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Frank		First P/	Middle Daugherty	Lost	4. DATE OF DEATH June 16	Month June	Day 16	Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 4/1889	9. AGE (In years last birthday) 68 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Hours 0	12. IF UNDER 24 HRS. Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) White washer		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Frank Daugherty				14. MOTHER'S MAIDEN NAME Mary Hearn				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —		17. INFORMANT RECORDS - Eastern Shore State Hospital		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Generalized arteriosclerosis DUE TO (c) Hemiparesis, left several yrs. several yrs.								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 494X Cerebral arteriosclerosis with psychosis								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ADDRESS (Street, city or town, state)						
20c. TIME OF INJURY Hour a. m. p. m.	Month Nov. 5	Day 19	Year 1952	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Mardela	20f. (City or town) Mardela	(County) Maryland	
21. I certify that I attended the deceased from Nov. 5, 1952 , to June 16, 1957 , that I last saw the deceased alive on June 16, 1957 , and that death occurred at 11:55 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Simon Virkutis M.D.								
DATE SIGNED								
ACTUAL SIGNATURE								
PHYSICIAN'S NAME (Type) Dr. Simon Virkutis		E.S.S. Hospital, Cambridge, Maryland				6-17-57		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-19-57	22c. NAME OF CEMETERY OR CREMATORIAL Mardela		22d. LOCATION (City, town, or county) Mardela Springs, Md.		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE Charles W. Mann - Layton				ADDRESS Dr. JUN 19 1957	REC'D BY REGISTRAR John Macay, Jr.	24b. REGISTRAR'S SIGNATURE		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit Permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.
REGEIV ED
JUN 19 1957

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

6287

CERTIFICATE OF DEATH

06263

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Caroline		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge		c. LENGTH OF STAY IN 1b 1 month		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridgely		d. STREET ADDRESS 05 x 22		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First WARREN	Middle EDWARD	Last DENISE	4. DATE OF DEATH	Month June	Day 26	Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 4/4/77	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) engineer		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Jay Edward Denise				14. MOTHER'S MAIDEN NAME Elizabeth Dixon				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 095-07-8046		17. INFORMANT Eastern Shore State Hospital records		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis								
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Senile Psychosis								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. s. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from May 21 , 1957, to June 26 , 1957, that I last saw the deceased alive on June 25 , 1957, and that death occurred at 8:50 AM , from the causes and on the date stated above.								
ACTUAL SIGNATURE Thomas J. Dredge M.D. ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) Thomas J. Dredge DATE SIGNED State Hosp. Cambridge Md 6-26-57								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 1, 1957		22c. NAME OF CEMETERY OR CREMATORIAL Hill Crest Cemetery		22d. LOCATION (City, town, or county) Federalsburg, Maryland (State)		
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton Son				ADDRESS Federalsburg, Md.		24a. REC'D BY REGISTRAR 6/28/57		
						24b. REGISTRAR'S SIGNATURE J. J. Frampton Son		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form 107-14

BUREAU V.

JUL 1 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06264

6270

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 13 Cambridge		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 5 Fairmount Ave		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Mary	Middle	Last	4. DATE OF DEATH	Month 6	Day 16	Year 1957
5. SEX	6. COLOR OR RACE Female	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH March 15, 1898	9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months 59	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Dorchester Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-32-0256		17. INFORMANT Benny Elliott, Cambridge, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0		Cardiac Decompensation				INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Arteriosclerotic heart disease							
DUE TO 434.3		(b)					
DUE TO Arteriosclerotic heart disease		(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 434.3						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED White at work <input type="checkbox"/> Nat white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Taylors Island	(County) Taylors Island, Md. (State) 6-17-57
21. I certify that I attended the deceased from April , 1957, to June 16 , 1957, that I last saw the deceased alive on June 16 , 1957, and that death occurred at 227 Pine St-Cambridge, Md. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6-17-57							
ACTUAL SIGNATURE <i>J. Edwin Fassett</i>	M.D.						
PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/20/1957	22c. NAME OF CEMETERY OR CREMATORIUM Taylors Island		22d. LOCATION (City, town, or county) Taylors Island, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hubert McElroy</i>		ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR 6/25/57	24b. REGISTRAR'S SIGNATURE <i>J. Edwin Fassett</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 may be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 27 1957

REGELY ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06265

6288

CERTIFICATE OF DEATH

Reg. Dist. No.

116

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Somerset		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge		c. LENGTH OF STAY IN 1b 2 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		d. STREET ADDRESS 310 Cove St.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First CAREY	Middle WELDON	Last EVANS	4. DATE OF DEATH June 6	Month June	Day 1957	Year
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/29/73		9. AGE (In years less birthday) 83 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) waterman		10b. KIND OF BUSINESS OR INDUSTRY Seaford		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME William Horace Evans		14. MOTHER'S MAIDEN NAME Rhoda Catherine Marsh						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. Sp. American		17. INFORMANT none		Address Eastern Shore State Hospital records		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized arteriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 304x Senile Psychosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Crisfield	(County) Md.	(State) Md.	
21. I certify that I attended the deceased from April 12, 1957, to June 6, 1957, that I last saw the deceased alive on June 6, 1957, and that death occurred at 10:30 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE Thomas J. Dredge M.D. E.S.S.H., Cambridge, Md. PHYSICIAN'S NAME (Type) Thomas J. Dredge DATE SIGNED 6/6/57								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 8/1957	22c. NAME OF CEMETERY OR CREMATORIAL American Legion Cemetery	22d. LOCATION (City, town, or county) Crisfield Md					
23. FUNERAL DIRECTOR'S SIGNATURE H. Harvey Bradshaw Crisfield	ADDRESS	24a. REC'D BY REGISTRAR DATE N 12 1957	24b. REGISTRAR'S SIGNATURE John Tracy Jr.					

THE ALABAMA STATE DEPARTMENT OF REVENUE
CERTIFICATE OF DEATH

RECEIVED

BUREAU V. S

JUN 12 1957

RECEIVED



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G217 6-24-57 et

06267

6271

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b entire life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gay & Spring Streets		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	
3. NAME OF DECEASED (Type or print) First Reginald		d. STREET ADDRESS Gay & Spring Streets	
4. DATE OF DEATH June 9, 1957		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 23, 1888
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Antique Furniture Repairman		10b. KIND OF BUSINESS OR INDUSTRY Self employed	
11. BIRTHPLACE (State or foreign country) Cambridge		9. AGE (In years last birthday) 68 yrs.	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Hampton Henry	
14. MOTHER'S MAIDEN NAME Octavia LeCompte		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No	
16. SOCIAL SECURITY NO. No		17. INFORMANT Mrs. Margaret S. Henry, Gay & Spring St., Cambridge, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Starvation		INTERVAL BETWEEN ONSET AND DEATH 3 mos	
163X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Toxic psychoses due to metastases of		2 mos	
(c) DUE TO Primerus Carcinoma of Lt lung		?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Alcoholism, chronic mild myalgia, hypertension		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Cambridge, Md. (County) Md. (State)	
21. I certify that I attended the deceased from June 9, 1957 to June 9, 1957 that I last saw the deceased alive on June 9, 1957 , and that death occurred at 7:50 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE James H. Thompson		ADDRESS (Street, city or town, state) Cambridge, Md. DATE SIGNED June 9, 1957	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 11, 1957	
22c. NAME OF CEMETERY OR CREMATORIAL Christ Church Cemetery		22d. LOCATION (City, town, or county) Cambridge, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth R. Thompson		ADDRESS Cambridge, Md.	
24a. REC'D BY REGISTRAR DATE 6/12/57		24b. REGISTRAR'S SIGNATURE Jaha Maca 71.	

WISCONSIN STATE CAPITAL - MADISON, WI

CERTIFICATE OF DEATH

BUREAU V. S.
RECEIVED
JUN 17 1957

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6289 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06268

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 4yr. 9mo. 21das.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eastern Shore State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Edgar Hilghman	First John	Middle Edgar	Last Hilghman
4. DATE OF DEATH June 17 1957	Month June	Day 17	Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 1-3-96
9. AGE (In years last birthday) 61	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hachinist	10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) Maryland (Fruitland)	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Theodore Hilghman	14. MOTHER'S MAIDEN NAME Elizabeth Watson		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. Disch'g. 6-6-19	17. INFORMANT Mrs. Dorothy P. Hilghman (Wife)	RECORDS — Eastern Shore State Hospital
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>John Mace Jr.</i>	DATE SIGNED 6/17/57		
EXAMINER'S NAME (Type) John Mace Jr.	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jun. 19, 1957	22c. NAME OF CEMETERY OR CREMATORIAL Shad Point Cemetery	22d. LOCATION (City, town, or county) (State) R.D. # Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.	ADDRESS —	24a. REC'D BY REGISTRAR DATE 6/20/57	24b. REGISTRAR'S SIGNATURE John Mace Jr.

BUREAU V. S.

JUN 24 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06270

6290

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Dorchester Co.</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Dorchester</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cambridge</i>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x/1 Rural - Cambridge</i>		d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Eastern Shore State Hospital</i>						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <i>Thomas</i>	Middle <i>William</i>	Last <i>Hubbard</i>	4. DATE OF DEATH	Month <i>June</i>	Day <i>6</i>	Year <i>1957</i>	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <i>July 4, 1888</i>	9. AGE (in years last birthday) <i>68</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>	13. CITIZEN OF WHAT COUNTRY? <i>M. S.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>M. S.</i>			
13. FATHER'S NAME <i>Samuel Edward Hubbard</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Rebecca Hubbard</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Mrs. M. J. James</i>		Address <i>RFD 3 Cambridge Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422.1</i>		Cardiac Failure				INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)		Chronic Cardiovascular Disease							
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <i>none</i>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. p. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>June 5</i> , 1957, to <i>June 6</i> , 1957, that I last saw the deceased alive on <i>June 6</i> , 1957, and that death occurred at <i>2:35 AM</i> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED			
ACTUAL SIGNATURE - <i>Ettore De Filippis</i>		M.D.		<i>Eastern Shore State Hospital</i>					
PHYSICIAN'S NAME (Type)									
22a. BURIAL, CREMATION, REMOVALS (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6/8/57</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Dail Family</i>		22d. LOCATION (City, town or county) (State) <i>RFD # 3, Cambridge, Md.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Le Compte Funeral Service</i>		ADDRESS <i>Cambridge, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>6/8/57</i>		24b. REGISTRAR'S SIGNATURE <i>John J. Moore</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE STATE OF HAWAII - SALINORE - 1

CERTIFICATE OF DEATH

NAME

BUREAU V.
RECEIVED
JUN 11 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6291

CERTIFICATE OF DEATH

Reg. Dist. No.

116

06271

1. PLACE OF DEATH a. COUNTY <i>Dorchester Co.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>RURAL Cambridge</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Graysontown</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Eastern Shore State Hospital</i>		d. STREET ADDRESS <i>17x22</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>John Paul Jones</i>		First <i>John</i>	Middle <i>Paul</i>
4. DATE OF DEATH <i>June 6 1957</i>		Last <i>Jones</i>	Month <i>June</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>1879</i>		9. AGE (in years lost/birthday) <i>78 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Waterman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Fishing</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>			
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>123-45-6789</i>	
17. INFORMANT <i>John Joseph A. Jones</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Failure</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>Chronic Cardiovascular Disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>422.1</i>	
DUE TO (b) <i>Chronic Cardiovascular Disease</i>			
DUE TO (c) <i>Chronic Cardiovascular Disease</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>June 6, 1957</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) <i>Eastern Shore State Hospital</i>
21. I certify that I attended the deceased from <i>June 5, 1957</i> to <i>June 6, 1957</i> , that I last saw the deceased alive on <i>June 6, 1957</i> , and that death occurred at <i>5389 M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Eastern Shore State Hospital</i>	
ACTUAL SIGNATURE <i>Ettore DeFilippis</i>		DATE SIGNED <i>M.D.</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6-10-57</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Grasonville</i>
22d. LOCATION (City, town, or county) <i>Grasonville</i>		(State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edgar L. Lanier</i>		23. ADDRESS <i>Church Hill Md.</i>	24a. REC'D BY REGISTRAR <i>DATE 13 1957</i>
			24b. REGISTRAR'S SIGNATURE <i>John Macay</i>

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06272

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 27 Charles Street		d. STREET ADDRESS 27 Charles Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Mary	Middle	Last Jones	4. DATE OF DEATH June 5, 1957	Month	Day	Year
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 15, 1891	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Dorchester Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Stephen Young		14. MOTHER'S MAIDEN NAME Emma Young		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Eli Young, Cambridge, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 48 hrs	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County)	(State)	
21. I certify that I attended the deceased from _____		June 3, 1957, to June 5, 1957, that I last saw the deceased alive on _____ 19 _____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state)					
ACTUAL SIGNATURE <i>J. Edwin Fassett</i>	DATE SIGNED 227 Pine St-Cambridge, Md. -6- 7-57						
PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/9/1957	22c. NAME OF CEMETERY OR CREMATORIUM Salem Cemetery		22d. LOCATION (City, town, or county) Salem, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Richard M. Clark</i>	ADDRESS Cambridge, Md.	24a. REC'D BY REGISTRAR DATE 6/10/57		24b. REGISTRAR'S SIGNATURE <i>John Macey Jr.</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6292

CERTIFICATE OF DEATH

Reg. Dist. No. 07407

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smithsville		c. LENGTH OF STAY IN 1b Life		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Smithsville		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Mary		First E.	Middle Keene	
4. DATE OF DEATH June 22 1957	Month Month	Day Day	Year Year	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 7, 1886	
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		
11. BIRTHPLACE (State or foreign country) Dorchester Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Robert Opher		14. MOTHER'S MAIDEN NAME Annie Wilson		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-09-0716		
17. INFORMANT William L. Keene, Smithsville, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Starvation + Malnutrition DUE TO 4500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Senile psychosis (c) Arterio-sclerosis generalized		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 304X		
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1957 to June 23, 1957 , that I last saw the deceased alive on June 20, 1957 , and that death occurred at M , from the causes and on the date stated above. ACTUAL SIGNATURE James L. Thompson M.D. DATE SIGNED June 23, 1957				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/26/1957	22c. NAME OF CEMETERY OR CREMATORIUM Smithsville Cemetery	22d. LOCATION (City, town, or county) Smithsville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Herb M. Schlesinger		ADDRESS Cambridge, Md.	24a. REC'D BY REGISTRAR DATE 7/8/57	24b. REGISTRAR'S SIGNATURE John Mace

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY DORCHESTER		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY WICOMICO					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE		c. LENGTH OF STAY IN 1b 6 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) POWELLVILLE (Powellville)		d. STREET ADDRESS R.D. # 1 Pittsville 22X12					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EASTERN SHORE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print)	First ADDIE	Middle MAE	Last KELLEY	4. DATE OF DEATH JUN 18 1957	Month JUN	Day 18	Year 1957				
5. SEX F.	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH AUG 22 1894	9. AGE (In years lost birthday) 62 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) (R.D. # 1 Willards)		12. CITIZEN OF WHAT COUNTRY? WICOMICO USA					
13. FATHER'S NAME JOHN HENRY PARKER		14. MOTHER'S MAIDEN NAME LOUISIANA Adkins									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Robert W. Kelley (Husband) R.D. # 1 Pittsville HOSPITAL RECORDS		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO 260X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) HEMIPLEGIA DUE TO (c) DIABETES MELLITUS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 334X CEREBRAL ARTERIOSCLEROSIS			INTERVAL BETWEEN ONSET AND DEATH 4 HRS.		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from JUNE 11, 1957 to JUNE 18, 1957 that I last saw the deceased alive on JUNE 18, 1957 , and that death occurred at 1:50 AM from the causes and on the date stated above. ACTUAL SIGNATURE Harry J. Crawford PHYSICIAN'S NAME (Type) HARRY J. CRAWFORD MD ADDRESS ESSH CAMBRIDGE MD JUNE 18 1957		ADDRESS (Street, city or town, state) ADDRESS (Street, city or town, state) M.D. 255 H-Cambridge, Md. June 18, 1957		DATE SIGNED DATE SIGNED							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jun. 21, 1957		22c. NAME OF CEMETERY OR CREMATORIAL Perdue Cemetery		22d. LOCATION (City, town, or county) Powellville, Maryland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		ADDRESS HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		24a. REC'D BY REGISTRAR DATE 6/20/57		24b. REGISTRAR'S SIGNATURE John Mace Jr.					

THE STATE OF HAWAII - SATURDAY, JUNE 24, 1957

CERTIFICATE OF DEATH

DEATH

BUREAU V. A.

JUN 24 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to removal.

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DEPARTMENT OF HOMELAND SECURITY - ALASKA STATE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S
JUN 27 1957
RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6273 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06275
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester Co.		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. LENGTH OF STAY IN 1b 16 Days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Dorchester Co.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Md. Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Crapo Md.		d. STREET ADDRESS 1 Crapo Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Mollie		First Mollie	Middle Elizabeth	Last Kirwan	4. DATE OF DEATH June 18, 1957	Month June	Day 18	Year 1957		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 26, 1870	9. AGE (in years last birthday) 86 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	13. IF UNDER 24 HRS. Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Crapo Md.		12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME John Webster		14. MOTHER'S MAIDEN NAME Elizabeth Smith		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None			17. INFORMANT Mrs. Ogle Bradford	Address Crapo Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 9040		DUE TO Uremia		INTERVAL BETWEEN ONSET AND DEATH 3 days				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) Intratrochanteric fracture r. femur		DUE TO Leg "gave way" as she walked to auto.		16 days				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Leg "gave way" as she walked to auto.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20c. TIME OF INJURY Hour p. m. 6-2-1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Nr. Home		20f. (City or town) Crapo	(County) Dor.	(State) Md.		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <i>John Mace Jr.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 6/19/57						
EXAMINER'S NAME (Type) John Mace Jr.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 21, 1957		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Dorchester Mem. Park		22d. LOCATION (City, town, or county) Cambridge		(State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		24a. REC'D BY REGISTRAR DATE 6/19/57		24b. REGISTRAR'S SIGNATURE John Mace Jr.						

RECEIVED
BUREAU V. S.

JUN 24 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6295

CERTIFICATE OF DEATH

Reg. Dist. No.

06270

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock		c. LENGTH OF STAY IN lb 3 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 rural		d. STREET ADDRESS Williamsburg		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fisher Nursing Home				d. STREET ADDRESS /		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Hattie Hubbert Lord		First Middle Last		4. DATE OF DEATH June 22, 1957		Month June	Day 22	Year 1957
5. SEX fem.	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 21, 1979	9. AGE (In years lost birthday) 78 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Henry Hubbert			14. MOTHER'S MAIDEN NAME Mary Jane Gambrill			Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. none		17. INFORMANT Miss Madeline Lord Williamsburg, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 572.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) Chronic Colitis + Diverticulitis						INTERVAL BETWEEN ONSET AND DEATH 1 yr +		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 260x Scoliosis; Diabetes mellitus						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)
21. I certify that I attended the deceased from _____, 1950, to June 22, 1957, that I last saw the deceased alive on June 21, 1957, and that death occurred at 11:00 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE W.C. Harrison M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF June 26, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Hillcrest Cemetery		22d. LOCATION (City, town, or county) Federalsburg, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Sharon W. Williams		ADDRESS Federalsburg, Md.		24a. REC'D BY REGISTRAR DATE June 26, 1957		24b. REGISTRAR'S SIGNATURE Chas Hastings		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REGULATORY STATE GOVERNMENT OF HAWAII - DIVISION OF
CERTIFICATES OF DEATH

BUREAU V. 2
RECEIVED
JUL 1 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6296

CERTIFICATE OF DEATH

06277
116

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		b. COUNTY Wicomico	
c. LENGTH OF STAY IN 1b 23 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury 22122	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		d. STREET ADDRESS 824 Brown St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First George	Middle Washington	Last McNelia
4. DATE OF DEATH	Month June	Day 27	Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-11-1870
9. AGE (In years lost birthday) 86 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown	10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) Delaware	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Benny McNelia		14. MOTHER'S MAIDEN NAME Margaret Russell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. 217-12-4886	
17. INFORMANT EASTERN SHORE STATE HOSPITAL RECORDS		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4221 Chronic myocarditis INTERVAL BETWEEN ONSET AND DEATH			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arteriosclerosis, generalized			
DUE TO (c) Senile Brain Syndrome			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 355 Chronic Brain Syndrome Associated with Senile Brain Disease, W. Psy. Recd. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Chronic Brain Syndrome Associated with Senile Brain Disease, W. Psy. Recd.	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6/4/57, 19, to 6/27, 1957, that I last saw the deceased alive on 6/27, 1957, and that death occurred at 12:15 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE EDWIN J. WARD	ADDRESS (Street, city or town, state) M.D. Eastern Shore State Hosp. 6-27-57 DATE SIGNED Cambridge Md.		
PHYSICIAN'S NAME (Type) Edwin J. Ward, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-29-57	22c. NAME OF CEMETERY OR CREMATORIAL Smith Mills	22d. LOCATION (City, town, or county) Delmar, Del. (State)
23. FUNERAL DIRECTOR'S SIGNATURE John Ward	ADDRESS	24a. REC'D BY REGISTRAR DATE 11 1 1957	24b. REGISTRAR'S SIGNATURE John Mace Jr.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 may be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

NY - CERTIFICATE OF DATA

BUREAU V. S.

JUL 1 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6274

CERTIFICATE OF DEATH

06278

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Dorchester Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. LENGTH OF STAY IN 1b 1 Week		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Toddville Md.		d. STREET ADDRESS 1 Toddville Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md. Hospital				d. STREET ADDRESS 1 Toddville Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Lewis	Middle W.	Last Meredith	4. DATE OF DEATH June 21	Month Month	Day 21	Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 31, 1872	9. AGE (In years last birthday) 85	10. IF UNDER 1 YEAR Months 85	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Fishing		11. BIRTHPLACE (State or foreign country) Toddville Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Not Known		14. MOTHER'S MAIDEN NAME Not Known					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Eldridge Smith		Address Cambridge Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure INTERVAL BETWEEN ONSET AND DEATH DUE TO 450.0							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arteriosclerosis DUE TO (c) Trimony Anemia 8405							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arthrosclerosis 290.3 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) 104 Locust (State) MD.	
21. I certify that I attended the deceased from June 14, 1957 to June 21, 1957 , that I last saw the deceased alive on June 21, 1957 , and that death occurred at 4:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) W. H. Hanks 104 Locust MD. DATE SIGNED 6/21/57							
ACTUAL SIGNATURE W. H. Hanks		PHYSICIAN'S NAME (Type) W. H. Hanks CAMBRIDGE MARYLAND					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 23, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Dorchester Mem Park		22d. LOCATION (City, town, or county) Cambridge Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge Md.		24a. REC'D BY REGISTRAR John Mace Jr.		24b. REGISTRAR'S SIGNATURE	
VS A15 (4) 1SM 9/55		DATE 6/24/57		DATE 6/24/57		DATE John Mace Jr.	

BUREAU U. S.

JUN 27 1957

REGIYED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6297 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

06279

Reg. Dist. No.

116

1. PLACE OF DEATH a. COUNTY Dorchester				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN lb 5 mos. 19 das.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stockton		b. COUNTY Worcester		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eastern Shore State Hospital				d. STREET ADDRESS —				
3. NAME OF DECEASED (Type or print) Charles		First Charles	Middle H.	Last Merritt	4. DATE OF DEATH June 4 1957	Month June	Day 4	Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 9-28-80		9. AGE (In years last birthday) 76 yrs.	10. IF UNDER 1 YEAR Months 0		11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY House		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Thomas Merritt				14. MOTHER'S MAIDEN NAME Susan - Marshall				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 401		17. INFORMANT Eastern Shore State Hospital records		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 902.7 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Generalized arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 10 min.								
DUE TO (b) Intertrochanteric fracture of right hip 5 yr. plus								
DUE TO (c) Intertrochanteric fracture of right hip 5-30-57								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? Ch.Br.Sy.Assoc. With Cerebral Arteriosclerosis With Psychotic Reaction YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 7:30 a.m. 5-30-57		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Patient fell while trying to get out of chair						
20c. TIME OF INJURY Hour 7:30 a.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) E.S.S.Hospital		20f. (City or town) Near Cambridge	(County) Dorchester, Md.	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE Eldridge H. Wolff		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					DATE SIGNED 6-4-57	
EXAMINER'S NAME (Type) Eldridge H. Wolff								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 1957		22c. NAME OF CEMETERY OR CREMATORIAL Chesapeake		22d. LOCATION (City, town, or county) Stockton		(State) MD
23. FUNERAL DIRECTOR'S SIGNATURE Elay G. Lewis		ADDRESS Smith Hill Rd		24a. REG'D BY REGISTRAR JUN 6 1957		24b. REGISTRAR'S SIGNATURE J. Moore Jr		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to trial, cremation,

VS. A15ME(5)
5M 9/55

AMERICAN STATE INFORMATION SERVICE
MEDICAL DOCUMENTS OF SOVIET

BUREAU Y.

JUN 6 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06280

6298

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge		c. LENGTH OF STAY IN lb 10 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela Springs 22 x 22			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First WALLACE	Middle Ivan	Last MILLIKEN	4. DATE OF DEATH	Month June	Day 11	Year 1957
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 9/15/97	9. AGE (In years lost birthday) 59 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. DAYS	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) N.Y. Linwood New York, N.Y.		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME J. David Milliken		14. MOTHER'S MAIDEN NAME Charlotte Angelica Minto.					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO.		17. INFORMANT Eastern Shore State Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		Coronary thrombosis		Miss MILDRED J. MILLIKEN (Sister) Mardela, Maryland		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		(b)					
(c)		DUE TO					
355. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mental Deficiency without psychosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Mardela Cemetery	20f. (City or town) Mardela, Maryland	(County) (State)
21. I certify that I attended the deceased from May 1952 to June 11, 1957, that I last saw the deceased alive on June 11, 1957, and that death occurred at 8 a. m., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Thomas J. Dredge M.D. E.S.S. Hospital, Cambridge, Md. 6/11/57							
PHYSICIAN'S NAME (Type) Thomas J. Dredge							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 13. 57.	22c. NAME OF CEMETERY OR CREMATORIAL Mardela Cemetery		22d. LOCATION (City, town, or county) Mardela, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Holloway & Co.				ADDRESS Salisbury, Maryland.		24a. REC'D BY REGISTRAR DATE 6/15/57	
						24b. REGISTRAR'S SIGNATURE John Mace Jr.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
Page 3 should be attached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S

JUN 17 1952

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6275 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06281

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Dorchester Co.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge Md.		d. STREET ADDRESS Cambridge Md.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Home Cambridge Md.				d. STREET ADDRESS Cambridge Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Sarah F.		First	Middle	Last	4. DATE OF DEATH Moore	Month	Day	Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) April 8, 1871	86 yrs.	10. IF UNDER 1 YEAR Months 11 Days 19 Hours 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Neck Dist., Dorchester Co.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Nemiah Beckwith				14. MOTHER'S MAIDEN NAME Frances Mitchell				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Willard Moore		Address Cambridge RFD # 3 Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH 10 hrs.		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cerebral vascular accident						
331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)						
		DUE TO						
		(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>								
ACTUAL SIGNATURE <i>John Mace Jr.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 6/12/57				
EXAMINER'S NAME (Type) John Mace Jr.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 13, 1957	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Greenlawn Cemetery	22d. LOCATION (City, town, or county) Cambridge		(State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		24a. REC'D BY REGISTRAR 6/12/57		24b. REGISTRAR'S SIGNATURE John Mace Jr.				
VS. A15ME(S) 5M 9/55								

ILLINOIS STATE DEPARTMENT OF LABOR - GATTINGS 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 5

JUN 17 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6299

CERTIFICATE OF DEATH

06282/16
Reg. Dist. No. 64

1. PLACE OF DEATH a. COUNTY Dorchester		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 1yr. 1mo. 24days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Caroline	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Denton 05X12		d. STREET ADDRESS Rt.2		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John		First Middle Wesley		Last Nichols		4. DATE OF DEATH June 6 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 10-18-83		9. AGE (In years lost birthday) 73 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Alex Nichols		14. MOTHER'S MAIDEN NAME Sarah Murphy							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -		17. INFORMANT Eastern Shore State Hospital Records		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1		Cardiac failure				INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		(b) Chronic cardiovascular disease							
DUE TO		(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 6-5, 1957, to 6-6, 1957, that I last saw the deceased alive on 6-6, 1957, and that death occurred at 8:45 A.M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>Ettore DeFilippis</i> M.D.						ADDRESS (Street, city or town, state)			
PHYSICIAN'S NAME (Type) Ettore DeFilippis				E.S.S. Hospital, Cambridge, Maryland 6-6-57		DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF June 9, 1957		22c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Cem.		22d. LOCATION (City, town, or county) Federalsburg, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Harvey Williamson</i>		ADDRESS Federalsburg		24a. REC'D. BY REGISTRAR Date 6/9/57		24b. REGISTRAR'S SIGNATURE <i>Errett Hattie Deputy</i> John Mac, Jr.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it
should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED STATE DEPARTMENT OF HUMAN-SERVICING, I
CERTIFICATE OF DEATH

BUREAU V. S

JUN 11 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06284

6300

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 29 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City		d. STREET ADDRESS -			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) George		First —	Middle —	Last Payne	4. DATE OF DEATH June	Month 12	Day 19	Year 57	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 11-23-82		9. AGE (In years lost birthday) 74 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired farmer		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Isaac Payne				14. MOTHER'S MAIDEN NAME Mary Ann Dueberry					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. —		17. INFORMANT RECORDS -Eastern Shore State Hospital		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> 4343						INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		(b) <u>Chronic Cardiac Disease</u> DUE TO							
		(c) <u>General Arteriosclerosis</u> DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 450.0						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. f. p. m.		Month 19	Day	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Chesapeake City	(County) Cecil	(State) Md.	
21. I certify that I attended the deceased from <u>June 11</u> , 1957, to <u>June 12</u> , 1957, that I last saw the deceased alive on <u>June 12</u> , 1957, and that death occurred at <u>10:30 p.m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Ettore De Filippis</u> M.D. E.S.S. Hospital, Cambridge, Maryland 6-12-57									
PHYSICIAN'S NAME (Type) Dr. Ettore DeFilippis									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 15, 1957		22c. NAME OF CEMETERY OR CREMATORIAL Bethel Cemetery		22d. LOCATION (City, town, or county) 2d. Chesapeake City, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Henry Peppi		ADDRESS Elkton, Md.		24a. REC'D BY REGISTRAR JUN 17 1957		24b. REGISTRAR'S SIGNATURE John Neasey			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by "funeral director, page 3 should be attached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1957 JUN 17

РЕГЕЛИЗО

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6276

06285

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Dorchester Co.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. LENGTH OF STAY IN Tb Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		d. STREET ADDRESS 317 Oakley St.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 317 Oakley St.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Miriam		First Eugene	Middle Phillips	Last Phillips	4. DATE OF DEATH June	Month June	Day 17	Year 1957
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH Jan. 23, 1897	9. AGE (In years lost birthday) 60 Yrs.	IF UNDER 1 YEAR Months 60	IF UNDER 24 HRS. Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Cambridge Md.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Robert E. Phillips				14. MOTHER'S MAIDEN NAME Elizabeth Mowbray				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Eliza beth Phillips		Address 317 Oakley St.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Disease -						INTERVAL BETWEEN ONSET AND DEATH 5 months		
DUE TO 241X Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) Congestive Heart Failure								
DUE TO 1320.1 (c) Bronchial Asthma						20 yrs.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 420.1						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 136 Race St.	(County) Cambridge	(State) Md.		
21. I certify that I attended the deceased from alive on 6/17/57 , 1957, to 6/17/57 , 1957, and that death occurred at 9:00 AM , from the causes and on the date stated above. ACTUAL SIGNATURE Lawrence Marynor				ADDRESS (Street, city or town, state) 136 Race St.		DATE SIGNED 6/18/57		
PHYSICIAN'S NAME (Type) Lawrence Marynor MD								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 19, 1957	22c. NAME OF CEMETERY OR CREMATORIUM Christ Church	22d. LOCATION (City, town, or county) Cambridge	(State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge Md.	24a. REC'D BY REGISTRAR DATE 6/19/57 John Mace Jr.	24b. REGISTRAR'S SIGNATURE				

DEPARTMENT OF STATE
CABLEGRAM TO BEACON

BUREAU V.

JUN 24 1957

REGELVÉD

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE. 18

6301

CERTIFICATE OF DEATH

06286/6

Reg. Dist. No

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Kent		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN lb 1 mo. 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		d. STREET ADDRESS - - -		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital				d. STREET ADDRESS - - -		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Florence		First Reese	Middle Robinson	Lost	4. DATE OF DEATH June 18	Month June	Day 18	Year 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 1877 ?	9. AGE (In years lost birthday) 79?	IF UNDER 1 YEAR Months 79?	IF UNDER 24 HRS. Days 79?	Hours 79?	Min. 79?
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Don't Know		14. MOTHER'S MAIDEN NAME Don't Know						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. - - -		17. INFORMANT RECORDS - Eastern Shore State Hospital		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0		Cardiac Failure				INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. } DUE TO (b) Chronic Cardiac Disease								
} DUE TO (c) General Arteriosclerosis								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 1134.3						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) M.D. E.S.S. Hospital, Cambridge, Maryland	(County) 6-19-57	(State) Maryland	
21. I certify that I attended the deceased from June 17 , 1957, to June 18 , 1957, that I last saw the deceased alive on June 18 , 1957, and that death occurred at 8:55 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6-19-57 DATE SIGNED								
ACTUAL SIGNATURE Ettore DeFilippis								
PHYSICIAN'S NAME (Type) Dr. Ettore DeFilippis								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 21-1957	22c. NAME OF CEMETERY OR CREMATORIUM Chestertown Cemetery	22d. LOCATION (City, town, or county) Chestertown, Maryland		(State) Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		ADDRESS Chestertown, Md.	24a. REC'D BY REGISTRAR JUN 21 1957		24b. REGISTRAR'S SIGNATURE John Macrae			

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/interment permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

REUREAU V. S.

-2501 TO NRI

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AN 01 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06287

6277

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b RURAL and give nearest town		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X/ RFD # 3, Cambridge, Md.		d. STREET ADDRESS /		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Maryland Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Russell		First V.	Middle Ryder	Last	4. DATE OF DEATH 6	Month 6	Day 28	Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/11/1885		9. AGE (In years last birthday) 71 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanical engineer		10b. KIND OF BUSINESS OR INDUSTRY Public transportation		11. BIRTHPLACE (State or foreign country) Owls Head, Maine		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Not known		14. MOTHER'S MAIDEN NAME Not known						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Not known		17. INFORMANT Edward Mitchell, RFD # 3, Cambridge, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331 X		<i>Cerebral Hemorrhage</i>		INTERVAL BETWEEN ONSET AND DEATH 12 hours				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) 444 X		<i>Hypertension</i>		5 yrs				
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 444 X				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. p. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 6/27	(County) 6/27	(State) 6/27
21. I certify that I attended the deceased from alive on 6/28 , 1952, and that death occurred at 10 AM , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) 136 Race St				
ACTUAL SIGNATURE Lawrence Maryanov	M.D.		DATE SIGNED					
PHYSICIAN'S NAME (Type) Lawrence Maryanov			<i>Cambridge, Md</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/2/57	22c. NAME OF CEMETERY OR CREMATORIAL Mt. Wollaston Cemetery		22d. LOCATION (City, town, or county) Quincy, Mass.		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service, Cambridge, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE 7/1/57	24b. REGISTRAR'S SIGNATURE John Mace Jr.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
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the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

HAWAIIAN STATE GOVERNMENT - DEPARTMENT OF HEALTH - CALIFORNIA

CERTIFICATE OF DEATH

100-2000

MURKIN

WILSON

BUREAU Y. S

JUL 8 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6278

CERTIFICATE OF DEATH

Reg. Dist. No. 06288

1. PLACE OF DEATH a. COUNTY Dorchester Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Dorchester Co.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. LENGTH OF STAY IN 1b 3 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		d. STREET ADDRESS 10½ Muse St.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md. Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Emerson		First	Middle	Last	4. DATE OF DEATH Seward	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 1892	9. AGE (In years last birthday) 65	10. IF UNDER 1 YEAR Months 6	11. IF UNDER 24 HRS. Days 5	12. IF UNDER 24 HRS. Hours 57
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Neck Dist. Dorchester Co.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME James Seward				14. MOTHER'S MAIDEN NAME Ella Todd		Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Dale Suffler		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Coronary Occlusion DUE TO 6 days		
19. INTERVAL BETWEEN ONSET AND DEATH 6 days		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 2658 diabetes		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) 2658		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20c. TIME OF INJURY Hour a. m. p. m. 19		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Speddens - Seward	20f. (City or town) Cambridge	(County) James Md.	(State) MD	
21. I certify that I attended the deceased from 12-13-55 , to 6-25 , 19 57 , that I last saw the deceased alive on 6-25 , 19 57 , and that death occurred at 12-14 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cambridge, Md. 21613								
ACTUAL SIGNATURE S. B. Bennerman		DATE SIGNED 6-28-57						
PHYSICIAN'S NAME (Type) Speddens - Seward								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 28, 1957		22c. NAME OF CEMETERY OR CREMATORIAL Speddens - Seward		22d. LOCATION (City, town, or county) James Md.		
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge Md.		24a. REC'D BY REGISTRAR 7/1/57 John Macoy		24b. REGISTRAR'S SIGNATURE		

FORM B CERTIFICATE OF DEATH

RECEIVED
BUREAU Y.
JUL 8 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6302

CERTIFICATE OF DEATH

Reg. Dist. No.

06289
116

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge		c. LENGTH OF STAY IN lb 4 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge 13				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First JAMES	Middle	Last SPEAR	4. DATE OF DEATH June 6	Month 1957	Day Year	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH August 7/8/13	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) waterman		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME John Spear		14. MOTHER'S MAIDEN NAME Mary Thompson		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. none		17. INFORMANT Eastern Shore State Hospital records		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u>		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. 420.1		(b) DUE TO		(c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 304. <u>Senile Psychosis</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21. I certify that I attended the deceased from <u>Feb 5</u> , 1954, to <u>June 6</u> , 1957, that I last saw the deceased alive on <u>June 6</u> , 1957, and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <u>Thomas J. Dredge</u> M.D. E.S.S. Hospital, Cambridge, Md. 6/6/57 DATE SIGNED								
PHYSICIAN'S NAME (Type) Thomas J. Dredge		22a. BURIAL, CREMATION, OR REMOVAL (Specify) June 8 1957		22b. DATE THEREOF June 8 1957		22c. NAME OF CEMETERY OR CREMATORIAL Hurlowak		22d. LOCATION (City, town, or county) Hurlowak Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE R. B. Wetherby		ADDRESS Hurlowak Md.		24a. REC'D BY REGISTRAR DATE JUN 17 1957		24b. REGISTRAR'S SIGNATURE John Mace Jr.		

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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DEPARTMENT OF DEFENSE - BUREAU OF INVESTIGATION
CERTIFICATE OF DEATH

BUREAU V. B.

JUN 17 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6279

CERTIFICATE OF DEATH

07422

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7 Fairmount Ave.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge	
d. STREET ADDRESS 7 Fairmount Ave.		d. STREET ADDRESS 7 Fairmount Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Preston		First	Middle
		Last	Stanley
4. DATE OF DEATH		Month	Day
		June	23, 1957
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 3, 1898
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days
		Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Food Packing	11. BIRTHPLACE (State or foreign country) Dorchester Co., Md.
		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Stanley		14. MOTHER'S MAIDEN NAME Mary Wilson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-07-9863	17. INFORMANT Amelia Stanley, Cambridge, Md.
		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH June 23, 1957	
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		?	
DUE TO (b) Arterio-sclerotic gen		?	
DUE TO (c) Hypertension CVRD		about 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 442X		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cambridge, Md.		DATE SIGNED July 1, 1957	
ACTUAL SIGNATURE John Thompson		M.D.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/27/1957	22c. NAME OF CEMETERY OR CREMATORIAL Smithsville Ceme.
		22d. LOCATION (City, town, or county) Smithsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Hubert Maryland		24a. REC'D BY REGISTRAR 7/8/57	24b. REGISTRAR'S SIGNATURE John Mace Jr.
		DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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CERTIFICATE OF DEATH

WISCONSIN

DEATH CERTIFICATE

REGISTRATION

EXPIRATION

BUREAU V. S

JUL 10 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be attached for use on the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6303

CERTIFICATE OF DEATH

06291
116

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge		c. LENGTH OF STAY IN 1b St. Michaels		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Talbot	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Michaels		d. STREET ADDRESS 20 x 02		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) AMELIA		First BELLE	Middle TARR	4. DATE OF DEATH June 19 19 57	Month JUN	Day 19	Year 1957		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 7/2/83		9. AGE (In years lost birthday) 73 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) school teacher		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME J. Yewell Tarr		14. MOTHER'S MAIDEN NAME Martha Donovan							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Eastern Shore State Hospital records		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocardial degeneration</u> 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Psychosis with cerebral arteriosclerosis 334X								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) St. Michaels		(County) St. Michaels		(State) Md.		
21. I certify that I attended the deceased from <u>April 24, 1957</u> , to <u>June 19, 1957</u> , that I last saw the deceased alive on <u>June 19, 1957</u> , and that death occurred at <u>1:15 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <u>Thomas J. Dredge M.D.</u> DATE SIGNED <u>6-19-57</u>									
PHYSICIAN'S NAME (Type) Thomas J. Dredge									
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/22/57	22c. NAME OF CEMETERY OR CREMATORIAL OLIVET Cemetery		22d. LOCATION (City, town, or county) St. Michaels		(State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas J. Marshall</u>		ADDRESS St. Michaels		24a. RECD BY REGISTRAR JUN 24 1957		24b. REGISTRAR'S SIGNATURE John Mace, Jr.			

CERTIFICATE OF DEATH

1957

BUREAU V. S.
RECEIVED
JUN 24 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07425

6280

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 8 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		d. STREET ADDRESS Cross Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Md. Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Doris		First	Middle	Last	4. DATE OF DEATH June 19, 1957	Month	Day	Year	
5. SEX Female		6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 31, 1929		9. AGE (In years lost birthday) 28 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. DAYS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Food Packing		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Collins Banks		14. MOTHER'S MAIDEN NAME Maryha Stanley		Address Martha Stanley Banks, Cambridge, Md					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 1 day
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		21. I certify that I attended the deceased from 6/19 , 1957 to 6/20 , 1957, that I last saw the deceased alive on 6/20 , 1957, and that death occurred at 12:35 A.M. , from the causes and on the date stated above. ACTUAL SIGNATURE Lawrence Maryanov PHYSICIAN'S NAME (Type) Lawrence Maryanov			DATE SIGNED 6/24/57
20c. TIME OF INJURY Month, Day, Year Hour o. p. p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 6/19 , 1957 to 6/20 , 1957, that I last saw the deceased alive on 6/20 , 1957, and that death occurred at 12:35 A.M. , from the causes and on the date stated above. ACTUAL SIGNATURE Lawrence Maryanov PHYSICIAN'S NAME (Type) Lawrence Maryanov		22b. DATE THEREOF 6/24/1957		22c. NAME OF CEMETERY OR CREMATORIUM Trappe Cemetery		22d. LOCATION (City, town, or county) Trappe, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Robert M. Clark		ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR DATE 7/8/57		24b. REGISTRAR'S SIGNATURE Jane Macey			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 11

Jul 10 1957

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6304 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06292

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Dorchester MARYLAND		a. STATE MD.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb	
Harkness		16 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
Harkness		/	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
WILLIAM BURTON VENABLE		Month Day Year Jun 27 1957	
5. SEX		6. COLOR OR RACE	
Male		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH		9. AGE in years (at birthday)	
7/1/77		74 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
None		—	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Maryland		U.S.A	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
George Venable		Mary Stokes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
No		220-17-1310	
17. INFORMANT		Address	
Marie J. Venable		Harkness	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		General Cancer -itis	
156.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		7 yrs	
DUE TO (b)		Carcinoma liver	
DUE TO (c)		—	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>		DATE SIGNED 6/27/57	
ACTUAL SIGNATURE JOHN MASE JR		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		22. BURIAL, CREMATION, OR REMOVAL (Specify) Burial 6/30/57	
22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS	
22d. LOCATION (City, town, or county) Baltimore, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE F. D. O'Leary, Jr.		24a. REC'D BY REGISTRAR DATE 6/28/57	
24b. REGISTRAR'S SIGNATURE John Mase			

WISCONSIN STATE MEDICAL EXAMINER'S OFFICE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V.

UL 1 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6305

Items 10a, 11, 13, 14 File #217 6-27-57 et

06293

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Dorchester</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cambridge</i>		c. LENGTH OF STAY IN lb <i>8 Mos bda</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Eastern Shore State Hospital</i>		e. STREET ADDRESS <i>514 Race St</i>	
3. NAME OF DECEASED (Type or print) <i>Robert</i>		First <i>Vincent</i>	Middle <i></i>
4. DATE OF DEATH <i>June 15</i>		Month <i>June</i>	Day <i>15</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 3 1885</i>
9. AGE (In years lost birthday) yrs. <i>71</i>		10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS. Days <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Dorchester Co., Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Robert Vincent</i>		14. MOTHER'S MAIDEN NAME <i>Laura Vane</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i></i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Hospital Records Cambridge Md</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>general Arteriosclerosis</i> DUE TO <i>450.0</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month <i>June</i>	Day <i>19</i>	Year <i>1956</i>
20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Cambridge</i>	(County) <i>MD</i>
21. I certify that I attended the deceased from <i>Oct 9</i> , 1956, to <i>June 15</i> , 1957, that I last saw the deceased alive on <i>June 14</i> , 1957, and that death occurred at <i>12:40 AM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Cambridge</i>			
ACTUAL SIGNATURE <i>Thomas T. Dredge</i>		DATE SIGNED <i>6-15-57</i>	
PHYSICIAN'S NAME (Type) <i>Thomas T. Dredge</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>6/17/57</i>	22b. DATE THEREOF <i>6/17/57</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>CAMBRIDGE MD</i>	22d. LOCATION (City, town, or county) <i>CAMBRIDGE MD</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>LECOMPTON FUNERAL SERVICES</i>		ADDRESS <i></i>	24a. REC'D BY REGISTRAR DATE <i>6/17/57</i>
			24b. REGISTRAR'S SIGNATURE <i>July 20 1957</i>

CERTIFICATE OF DEATH

BUREAU V. S.

JUN 24 1957

RECEIVED

6306 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 06294 16

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linkwood		c. LENGTH OF STAY IN 1b 6 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Merrick Convalescent Home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Linkwood	
3. NAME OF DECEASED (Type or print) Joseph		First Middle William	4. DATE OF DEATH June 26, 1957
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Laborer		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT Family Records		12. CITIZEN OF WHAT COUNTRY? U.S.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO attuo-sclerotic CVD & hypertension (c) DUE TO attuo - sclerotic granuloma		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Demplosia at (old) necrose.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 450.0	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While not while of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 27</u> , 1957, to <u>June 26</u> , 1957, that I last saw the deceased alive on <u>June 22</u> , 1957, and that death occurred at <u>1:00 AM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Cambridge, Md.	
ACTUAL SIGNATURE <u>R. E. Clark</u>		DATE SIGNED <u>John Mace, Jr.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 28, 1957	
22c. NAME OF CEMETERY OR CREMATORIUM Springhill Cemetery		22d. LOCATION (City, town, or county) (State) Easton, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. E. Clark</u>		ADDRESS Easton, Md.	
24a. REC'D BY REGISTRAR DATE 1 1957		24b. REGISTRAR'S SIGNATURE <u>John Mace, Jr.</u>	

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REGELIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										06295		
6281 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.		
1. PLACE OF DEATH o. COUNTY Dorchester MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Md. b. COUNTY Dorchester							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge			c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge Md.							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 223 Robbins St.					d. STREET ADDRESS 223 Robbins St.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Lee	Middle Ondos	Last Wheatley	4. DATE OF DEATH June 11 1957		Month June	Day 11	Year 1957			
5. SEX Male		6. COLOR OR RACE white	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 19, 1897		9. AGE (In years from birthday) 00 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Parts Manager			10b. KIND OF BUSINESS OR INDUSTRY Auto Garage			11. BIRTHPLACE (State or foreign country) Dorchester Co.			12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Joseph Wheatley					14. MOTHER'S MAIDEN NAME Catherine Collins							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes			16. SOCIAL SECURITY NO. World War I 220-12-1719			17. INFORMANT Mrs Lydia R. Wheatley 223 Robbins St.			Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH 20 Min.		
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion												
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1												
(b) Arterio Sclerosis												
DUE TO (c)												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .												
ACTUAL SIGNATURE <i>John Mace</i>										DATE SIGNED 6/15/57		
EXAMINER'S NAME (Type)												
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF June 13, 1957			22c. NAME OF CEMETERY OR CREMATORIUM Dorchester Mem. Park		22d. LOCATION (City, town, or county) Cambridge Md. (State)				
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service Cambridge, Md.					ADDRESS		24a. REC'D BY REGISTRAR DATE 6/15/57		24b. REGISTRAR'S SIGNATURE <i>John Mace Jr.</i>			

RECEIVED - MEDICAL SWIMMING CERTIFICATE OF DEATH
MEDICAL DEPARTMENT OF DEFENSE

BUREAU V. S

JUN 17 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6307

CERTIFICATE OF DEATH

06296
116

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Somerset		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 1 mo. 5 das.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		d. STREET ADDRESS ~		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First George	Middle Henry	Last Wilson	4. DATE OF DEATH	Month June	Day 18	Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 6-21-87	9. AGE (In years lost birthday) 69 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY ~		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Charles L. Wilson		14. MOTHER'S MAIDEN NAME Julia Shores						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 28-05-8797		17. INFORMANT RECORDS - Eastern Shore State Hospital		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		Cardiac Failure				INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day 19	Year 1957	20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Princess Anne, Md.	20f. (City or town) Princess Anne, Md.	(County) Princess Anne, Md.	(State) Md.
21. I certify that I attended the deceased from June 17, 1957 , to June 18, 1957 , that I last saw the deceased alive on June 18, 1957 , and that death occurred at 7:20 P.M. , from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>Ettore DeFilippis</i>	ADDRESS (Street, city or town, state) M.D. E.S.S. Hospital, Cambridge, Md.							DATE SIGNED 6-19-57
PHYSICIAN'S NAME (Type) Dr. Ettore DeFilippis								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-22-57	22c. NAME OF CEMETERY OR CEMETORY St. Andrew	22d. LOCATION (City, town, or county) Princess Anne, Md.	(State) Md.				
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lewis R. Wilson</i>	ADDRESS Princess Anne	24a. REC'D BY REGISTRAR 24-1957	24b. REGISTRAR'S SIGNATURE <i>John MacLean</i>					

CERTIFICATE OF DEATH

MURKIN

RECEIVED

JUN 24 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by
 page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6308

CERTIFICATE OF DEATH

06297

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Dorchester Co.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge RFD # 3		c. LENGTH OF STAY IN 1b 70 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge RFD # 3		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge RFD # 3	
3. NAME OF DECEASED (Type or print) Irvin		First Wingate	Middle Wingate
4. DATE OF DEATH June 25 1957		Last Wingate	Month June
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Nov. 8, 1871		9. AGE (In years last birthday) 85 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Fishing	
11. BIRTHPLACE (State or foreign country) Wingate Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Wingate		14. MOTHER'S MAIDEN NAME Laura Fallin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Alfred Wingate		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO 446X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Arterio and arteriolar nephrosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 177X Hemipelgia, right - 2 months. Carcinoma of prostate - 5 years.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. -- 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that I attended the deceased from July 3, 1942 , to June 20, 1957 , that I last saw the deceased alive on June 20, 1957 , and that death occurred at 5:30AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 15 Locust Street, Cambridge, Md. DATE SIGNED 6-26-57			
ACTUAL SIGNATURE Eldridge H. Wolff PHYSICIAN'S NAME (Type) Eldridge H. Wolff, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 27, 1957	
22c. NAME OF CEMETERY OR CREMATORIUM Greenlawn Cemetery		22d. LOCATION (City, town, or county) Cambridge (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge Md.	
24a. REC'D BY REGISTRAR DATE 7/1/57		24b. REGISTRAR'S SIGNATURE John Macay Jr.	

CERTIFICATE OF DEATH

MURKIN

MURKIN

BUREAU Y.
RECEIVED
JUL 8 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
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 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 File #C218 7-18-57 et

06298

6282

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		d. STREET ADDRESS 51B Douglas Street		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 51B Douglas St				d. STREET ADDRESS 51B Douglas Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Alverta		First Stewart	Middle Young	Last t	4. DATE OF DEATH Dec. 24, 1876	Month 6	Day 18	Year 1957
S. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 24, 1876		9. AGE (In years lost birthday) 81 80 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months 81 Days 80 Hours 0 Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Dorchester Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Frank Stewart		14. MOTHER'S MAIDEN NAME Mary Stewart						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mary Wingate, Cambridge, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation						INTERVAL BETWEEN ONSET AND DEATH		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Arteriosclerotic heart disease								
(b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from April , 1957, to June 18 , 1957, that I last saw the deceased alive on June 18 , 1957, and that death occurred at 1 P. M. , from the causes and on the date stated above. ACTUAL SIGNATURE <i>J. Edwin Fassett</i>				ADDRESS (Street, city or town, state)		DATE SIGNED 6-22-57		
PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/23/1957		22c. NAME OF CEMETERY OR CREMATORIUM Bethel Cemetery		22d. LOCATION (City, town, or county) Cambridge, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Herbert M. St. John Jr.</i>		ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR 6/25/57		24b. REGISTRAR'S SIGNATURE <i>John Mace Jr.</i>		

CERTIFICATE OF DEATH

100-0000000

BUREAU V. S.

- JUN 27 1957 -

RECEIVED